Maastricht University

Safe motherhood

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Summary

Limited access to and low utilization of facility-based maternal healthcare services have been shown to be the main reasons for the high maternal mortality ratio in Zambia (CSO, 2014). The aim of the research presented in this dissertation was to explore and investigate the psychosocial and environmental factors that affect utilization of maternal healthcare services in Kalomo, Zambia. We conducted several empirical studies (chapter 2 to 8) to explore the factors that affect utilization of maternal healthcare services in Kalomo, Zambia.

The qualitative study reported in **Chapter 2** aimed to explore the psychosocial and environmental factors that affect utilization of maternal healthcare services in Kalomo, Zambia. Data for this study were collected from twelve focus group discussions (n=141) with women of reproductive age (15-45 years), who gave birth within the previous year, and from 35 in-depth interviews with traditional leaders, mothers, fathers, community-health workers, and nurse-midwives, which were conducted in six health centre catchment areas. Perspectives on maternal health complications, health-seeking behavior and barriers to utilization of maternal healthcare were explored. The findings showed that most women had insight into maternal health complications. Nevertheless, they started antenatal care visits late and did not complete the recommended schedule. Moreover, most women gave birth at home and did not use postnatal care. The main reasons for the low utilization were the low perceived quality of maternal healthcare services in clinics (negative attitude), negative opinion of important referents (subjective norms), physical and economic barriers such as long distances, high transport and indirect costs including money for baby clothes and other requirements.

Chapter 3 reports findings of a quantitative study which aimed to identify important personal and psychosocial factors which predict a woman's intention to use maternal healthcare services in Kalomo, Zambia. Data for this study were collected using an interviewer-administered questionnaire which was administered among 1007 women of reproductive age (15-45 years) from 13 rural health centres with the lowest service utilization rates in the district. Questions included measures of (past) health-care seeking behavior, psychosocial variables (attitude, perceived social norms, perceived behavioral control), logistical barriers (e.g. distance to the clinic), and socio-demographic variables (e.g. age, income and education level). The findings of this study showed that most respondents had high intention to use healthcare services. Intention was positively associated with attitude, personal norms, behavioral control, education and income levels. Conversely, intention was negatively related to perceived social norms, age and distance. Multivariate regression analysis showed that, together, these variables accounted for 41.8% of the variance in intention, with perceived behavioral control being the strongest unique predictor of intention, followed by geographical distance and perceived social norms.

In **Chapter 4**, reasons motivating women to give birth at home and seek the help of traditional birth attendants (TBAs) were explored. Data for this study were collected from ten focus group discussions (n=100) with women of reproductive age (15-45 years), and from 30 in-depth interviews with 5 TBAs, 4 headmen, 4 husbands, 4 mothers, 4 neighbourhood health committee (NHC) members, 4 community health workers (CHWs) and 5 nurses in five health centre catchment areas with the lowest institutional delivery rates in the district. Perspectives on TBAs, the decision-making process regarding home delivery and use of TBAs, and reasons for preference of TBAs and their services were explored. The findings showed several reasons that prevent women from giving birth at the health centre, and also those that motivate women to give birth at home and use the services provided by TBAs. The main reasons preventing women from giving birth at the health centre included women's lack of decision-making autonomy regarding child birth, dependence on the husband and other family members for the final decision, and various physical and socioeconomic barriers including long distances, lack of money for transport and the requirement to bring baby clothes and food while staying at the clinic, prevented them from delivering at a clinic. Further, the findings showed that the main reasons motivating women to give birth at home were socio-cultural norms regarding childbirth, and negative attitude towards the quality of services in the facilities. The main reasons for preferring the services provided by the TBAs included women's positive attitude towards TBAs, perceiving TBAs to be respectful, skilled, friendly, trustworthy, and available when they needed them. The findings reported in these chapters (Chapter 2, 3 and 4) can serve as a starting point for the design of public health interventions that focus on increasing the utilization of maternal healthcare services and improve maternal and newborn health outcomes.

Chapter 5 aimed to explore the women's experiences and beliefs concerning utilization of maternity waiting homes (MWHs) in rural Zambia. Data for this qualitative study were collected from 32 in-depth interviews with women of reproductive age (15-45 years) from nine health centre catchment areas, 22 of which were conducted in 7 health centres with a MWH, and 10 were conducted in 2 health care facilities without a MWH. Women's perspectives on MWHs, the decision-making process regarding the use of MWHs, and factors affecting utilization of MWHs were explored. The findings showed that most women appreciated the important role MWHs play in improving access to skilled birth attendance and improving maternal health outcomes. However several factors such as women's lack of decision-making autonomy, prevalent gender inequalities, low socioeconomic status and socio-cultural norms prevent them from utilising these services. Moreover, lack of funds to buy the requirements for the baby and mother to use during labour at the clinic, concerns about a relative to remain at home and take care of the children and husband, and concerns about the poor state and lack of basic social and healthcare needs in the MWHs – such as adequate sleeping space, beddings, water and sanitary services, food and cooking facilities as well as failure by nurses and midwives to visit the mothers staying in the MWHs to ensure their safety, prevent women from using MWHs.

In **Chapter 6**, husbands' experience and beliefs regarding the use of maternity waiting homes (MWHs) in Kalomo District, Zambia were explored. Data for this study were collected from 24 in-depth interviews with the husbands aged 18-50 years who were married to the women of reproductive age, who were attending the under-five clinic at a health center with a MWH, and who had lived in the area for more than 6 months. The findings showed that husbands perceived many potential benefits of MWHs, including improved access to facility-based skilled delivery services and treatment in case of labor complications. Their many roles included decision making and securing funds for transport, food, cleaning materials, and clothes for the mother and the neonate to use during and after labor. However, limited financial resources made it difficult for them to provide for their wives and newborns, and usually led to husbands' delay in making decisions about MWH use. Poor conditions in MWHs and the lack of basic social and healthcare needs meant some husbands had forbidden their wives from using the facilities.

In **Chapter 7**, findings of a quantitative study are presented in which we aimed to confirm the relevance of the personal and environmental factors in explaining the use of MWHs, and compare the relevance of these factors between those with access and those who do not have access to MWHs. Data for this cross-sectional study were collected using an interviewer-administered questionnaire among 340 women of reproductive age in 15 rural health centres (that is, 203 from 10 clinics with MWHs and 137 from 5 without) in Kalomo district, Zambia. Questions included socio-demographic variables (age, parity, education, income level, and distance to the clinic), measures of past healthcare seeking behaviour, psychosocial variables (cognitive attitude, affective attitude, descriptive norms and injunctive norms, perceived behavioural control, risk perception and perceived barriers). Strong negatively skewed data patterns on the measures of interest prevented the use of regression analysis. Instead, scores of participants with and without access were compared on the outcome measures using tests of association (Chi-square, odds ratio) and mean difference scores (*t*-test). The findings showed that compared to respondents from health centres without MWHs, those from centres with MWHs were more likely to express a willingness to use MWHs, to perceive benefits from using a MWH, to perceive staying in a MWH as enjoyable, to perceive more social pressure from the important others to use MWH, to perceive personal risk from pregnancy and childbirth related complications, to go and stay at the clinic before delivery, to give birth at a health facility, and to receive care from a skilled birth attendant. In contrast, these respondents were less likely to perceive descriptive norms towards the use of a MWH, and less likely to perceive barriers regarding the use of a MWH. There was no significant association between the presence of a MWH and perceived behavioural control development of complications after childbirth, or use of antenatal and postnatal care. The results presented in chapter 5, 6 and 7 can serve as a basis for public health interventions focusing on improving access to MWHs and facility-based skilled birth attendance.

Chapter 8 aims to investigate the role of Safe Motherhood Action Groups (SMAGs) increasing utilization of skilled facility-based maternal healthcare services in rural Zambia and explores the perspectives, roles, achievements and challenges of the SMAG program in Kalomo, Zambia. Data for this study were collected from 46 in- depth interviews with 22 SMAG members, including 5 headmen, 10 mothers, 3 husbands, 5 nurses and 1 district maternal and child health coordinator conducted in 7 health centers in Kalomo district. Perspectives on the selection, training, roles, achievements and challenges of the SMAG program were explored. The findings demonstrated that respondents were aware of the presence, selection, training and roles of the SMAG members and had a positive attitude towards the programme. They believed that the SMAG programme led to an increase in women's risk perception about pregnancy and childbirth-related complications. Further, participants believed that the programme led to an increase in the women's utilization of facility-based antenatal, delivery and postnatal care, and thereby resulted in improvement in maternal and newborn health outcomes. However, various challenges affected implementation of the SMAG programme. Among these were lack of material and financial support to the programme, lack of refresher training for SMAG members, poor quality of care in health care facilities due to a lack of MWHs, low staffing levels in health facilities, the poor state and small size of the labour wards, and lack of equipment to handle obstetric emergencies. These findings suggest that a community-centred intervention such as a SMAG programme might be an important intervention for increasing utilization of facility-based skilled care and improving maternal and newborn health outcomes. Finally, **Chapter 9** provides a general discussion of all the empirical studies presented in this dissertation, and discusses the results in light of the existing literature, highlights the strengths and limitations of these studies, and the methods used to conduct the current research, and discusses the implications of the research findings which lead to recommendations for future research, and the development of new intervention programmes.